PAULDING COUNTY HOSPITAL

Self-Referral Colonoscopy Questionnaire

First Name:	Last Name:	Date of Birth:
Mailing Address to receive prep and procedure instructions:		
Daytime Telephone:	Evening Telephone:	
Referring/Primary Care Provider:	Referring/Primary Care Provider Phone #:	
Insurance Plan:	ID#:	Group#:
Insured:	Group Name:	
Preferred Pharmacy:		
Reason for Visit:		
Procedure Being Requested: Colonoscopy		
Ethnicity/Race: **Caucasian** **African-American** **Asian Pacific Islander** **Hispanic** **Race Unknown**		
Sex:	Height and Weight:	
If Female, Have you reached menopause? **Yes** **No**	Are you a female of child bearing age? **Yes** **No**	
NSAID Use: Advil, Motrin (Ibuprofen); Aleve (Naproxen sodium); Ascriptin, Bayer, Ecotrin (aspirin); Anaprox (naproxen sodium); Celebrex (celecoxib, sulindac); Daypro (oxaprozin, salsalate, diflunisal); Feldene (piroxicam) Indocin (indomethacin, etodolac); Mobic (meloxicam); Naprosyn (naproxen, nabumetone, ketorolac tromethamine); Vimovo (naproxen/esomeprazole); Voltaren (diclofenac)		
Anti-coagulant Use: (Plavix, Coumadin, Heparin, Lovenox, Pradaxa, Refludan, Arixtra, Xarelto, Eliquis, etc.)		
Allergies:		
Please list current medications and dosages:		

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Medical History

Previous Colon Cancer Screening: **Barium Enema** **Flex Sigmoidoscope** **Colonoscopy**

Date of last colonoscopy: **None** **<5 years** **Almost 5 years** **6-9 years** **>10 years**

What provider performed last colonoscopy procedure?

Result of Colonoscopy: Failed/Incomplete exam? **No Polyps** **<3 Polyps** **3-5 Polyps** **>5Polyps**

Do you feel you need to be evaluated for any of the following GI symptoms:

Blood in stool (K92.1) **Rectal Bleeding** (K62.5) **Abdominal pain** (R10.9) **Constipation** (K59.00) **Diarrhea** (R19.7) **Unexplained Weight Loss** (R63.4)

Pulmonary History: **Shortness of Breath** **COPD** **Asthma** **Cough** **Sleep Apnea**

Do you use a CPAP: **Yes** **No**

Have you had a heart attack: **Yes** **No**

Do you have a defibrillator or pacemaker: **Yes** **No**

Are you a diabetic: **Yes** **No**

Have you had previous surgeries: **Please List**

Prior Difficulty with Anesthesia or Sedation: **Yes** **No** If Yes: **Explain**

Do you drink alcohol: Amount (1 can of beer, 1 glass of wine, 1 shot of spirits=1 drink)

None **< 4 drinks/year** **Up to 3 drinks/week** **4-13 drinks/week** **14 or more drinks/week**

Did you ever smoke: **Yes** **No** How many packs/day did you smoke?

Have you quit smoking: **Yes** **No**

Do you have a parent or sibling who had colon cancer or rectal cancer: **Yes** **No**

If yes, then please put relationship and age at their diagnosis:

Please add any comments: